Engaging People with Disabilities:

Promoting Health Through Program Integration

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Safe and Active communities

California Department of PublicHealth

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Engaging People with Disabilities: Promoting Health Through Program Integration

OVERVIEW

It is imperative that we foster inclusion of people with disabilities into our policies and programs—it is the law but just as importantly, it reflects our public health commitment to reducing health disparities. However, we realize that it is not always easy to move from stated commitment to action. We understand that staff are willing to include people with disabilities into programs and interventions but may lack the knowledge of how or what to do in order to make that happen. This enclosed *Integration Packet* has been designed to help with implementation on many levels. It includes practical strategies, sample protocols, examples of educational materials, to-do lists, and model language that can be easily incorporated into existing program activities. The definitions of disability are varied and diverse. Packet materials are based on the following definition of disability:

> *Disability is currently defined as someone who is limited in any way in any activities because of a physical, mental, or emotional problem, or someone with a health problem that requires the use of special equipment, such as a cane, a wheelchair, a special bed, or a special telephone.*

BACKGROUND

The impetus for creating the *Integration Packet* was a LHD Policy Summit, convened by the CDPH's LHD Program, located within the SAC Branch. The Summit agenda was crafted by members from the LHD Advisory Committee as well as a CDPH and California Department of Health Care Services' (CDHCS) Disability Advisory Committees (DACs). The Summit included national and local speakers as well as breakout sessions to open up discussion with department managers, supervisors, and key staff on how disability issues could be better integrated into administrative and programmatic practices.

MATERIALS IN THE INTEGRATION PACKET REFLECT SUMMIT RECOMMENDATIONS

Summit participants felt that the following recommendations could be implemented within CDPH using existing resources or at minimal cost.

ADMINISTRATION

- Include people with disabilities in department-wide and programmatic strategic plans (not separately but integrated throughout).
- Improve internal departmental knowledge of overall and specific disability issues.
- Create and adopt inclusionary policies.
- Ensure that websites, and all content on the websites, are accessible.
- Ensure that all meetings involving department staff are accessible.
- Ensure that trainings given by the department include disability-related concerns/needs when appropriate.

PROGRAM INTEGRATION

- Target and train providers who serve people with disabilities in areas such as resource availability and best inclusionary practices.
- Create a packet of materials to aid programs in how to integrate people with disabilities into programs, services, data analyses, and evaluation.
- Provide the best practices for including people with disabilities in interventions.
- Ensure that people with disabilities are represented on program advisory committees and councils.
- Include related disability issues into webinars, trainings, and conferences.

MATERIALS DEVELOPMENT

- Ensure that new materials depict or represent persons with various types of disabilities.
- Ensure that materials posted on CDPH websites are accessible.
- Provide training and tools to managers and staff on how to create accessible materials including but not limited to developing captions for pictures and tables.
- Provide a database of acceptable images of people with disabilities.
- Evaluate health information distributed by programs for accessibility for persons with disabilities.

DATA ANALYSIS AND SURVEILLANCE

- Create a research resource group to help incorporate disability identifiers into surveillance activities.
- Identify programs that are collecting data on people with disabilities and programs that should be including disability in the data they collect.
- Improve interagency sharing of practices regarding the collection, use, analysis and dissemination of disability data.
- Improve distribution of disability-related data analyses internally and externally.

SUMMARY

California has been a leader in developing disability-related public policies that reflect the Americans with Disabilities Act (ADA) and California State law. This Integration Package provides practical strategies to strengthen public health-led efforts that embed inclusion into all of our programs. Let's model the way.

For more information—or to share your own integration successes – please contact Barb Alberson, Chief, State and Local Injury Control Section, at: Barbara.alberson@cdph.ca.gov.

CONTENTS

Disability Etiquette

WORDING AND TERMINOLOGY

AVOID/INAPPROPRIATE	USE/APPROPRIATE
The disabled, the handicapped	People with disabilities
Cripple	A person with a physical disability/ impairment or wheelchair user
Spastic	A person with cerebral palsy
Deaf and dumb	A person with hearing and speech impairments
The Blind	People who are B/blind, partially sighted, visually impaired
The Deaf	People who are D/deaf, hearing impaired
Crazy, insane, mentally ill	Emotional disorder(s), mental illness

(People who are Blind and/or Deaf consider themselves to be part of a minority hence the capitalization of the word Blind/Deaf is used in some circumstances).

INTERACTIONS

AVOID/INAPPROPRIATE	USE/APPROPRIATE
Raising your voice or talking as if speaking to a child.	Maintain your usual pitch volume and rhythm when speaking.
Interrupting a person with speech impairment and trying to finish sentences for them.	Listen patiently and ask for clarification if you have not understood.
Putting your hands near your mouth when communicating with someone.	Ensure that they have a clear view of your face.
Playing 'guess who' games with people who are blind or visually impaired.	Introduce yourself by name to a person who is blind.
Looking down at a person in a wheelchair for a prolonged period.	Sit down to make eye contact easier; it means they are not constantly craning their neck to look up at you.
Speaking to a person's friend or support worker when your conversation is directed at the person with a disability.	Speak directly to the person.

It is quite appropriate to continue using words such as see, look, walk, or listen when talking to people with various disabilities.

Source: Heriot Watt University, Advice for Staff-Disability Etiquette, Edinburgh, Scotland, Date, 2007w

Planning Accessible Events

It is important that every one is able to fully participate in any planned activity, meeting, or event. Please refer to this checklist when planning your events.

- Use appropriate and inclusive language when creating meeting/event invitations or announcements.
- Ascertain if anyone attending the event will need a sign language interpreter. Call the Office of Civil Rights (916) 445-0938 or http://cdphintranet/employees/Documents/Requesting%20Sign%20Language%20Interpreter.pdf to arrange for an interpreter. You need to give them at least one week's notice.
- Doors from the outside in to the facility (e.g., meeting room) open easily and are at least 32" wide.
- Event announcements and all event materials are available in alternate formats*.
- Event site has accessible parking.
- There is a clear path of travel to every part of the event room(s).
- Restrooms are accessible.
- The facility has accessible telephones, drinking fountains, and posted emergency evacuation plans.
- There is a podium that can be adjusted or easily moved.
- Tables are available to write on and to hold food and drinks.
- Chairs are easily removed from where participants using wheelchairs are slated to sit (e.g., at the table).
- Ascertain in advance if additional seating is needed for attendants.

*Accessible formats include braille, large print, audio tape, CD-ROM or flash drive, e-mail, and closed captioning. Ensure that electronic versions of materials are available in plain text (.txt), MSWord (.doc) or rich text (.rft). A PDF is not usually in an accessible format.

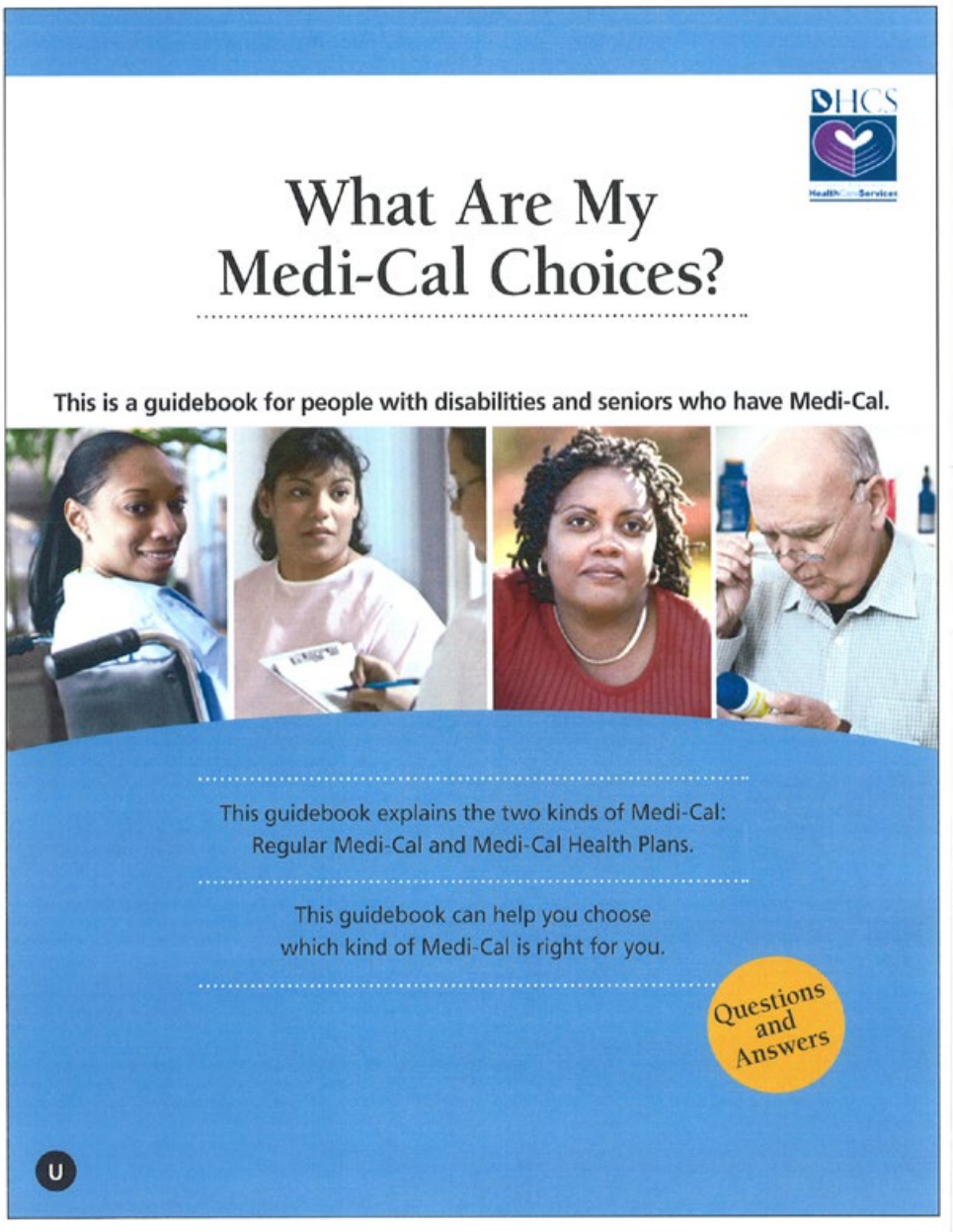
Materials Integration

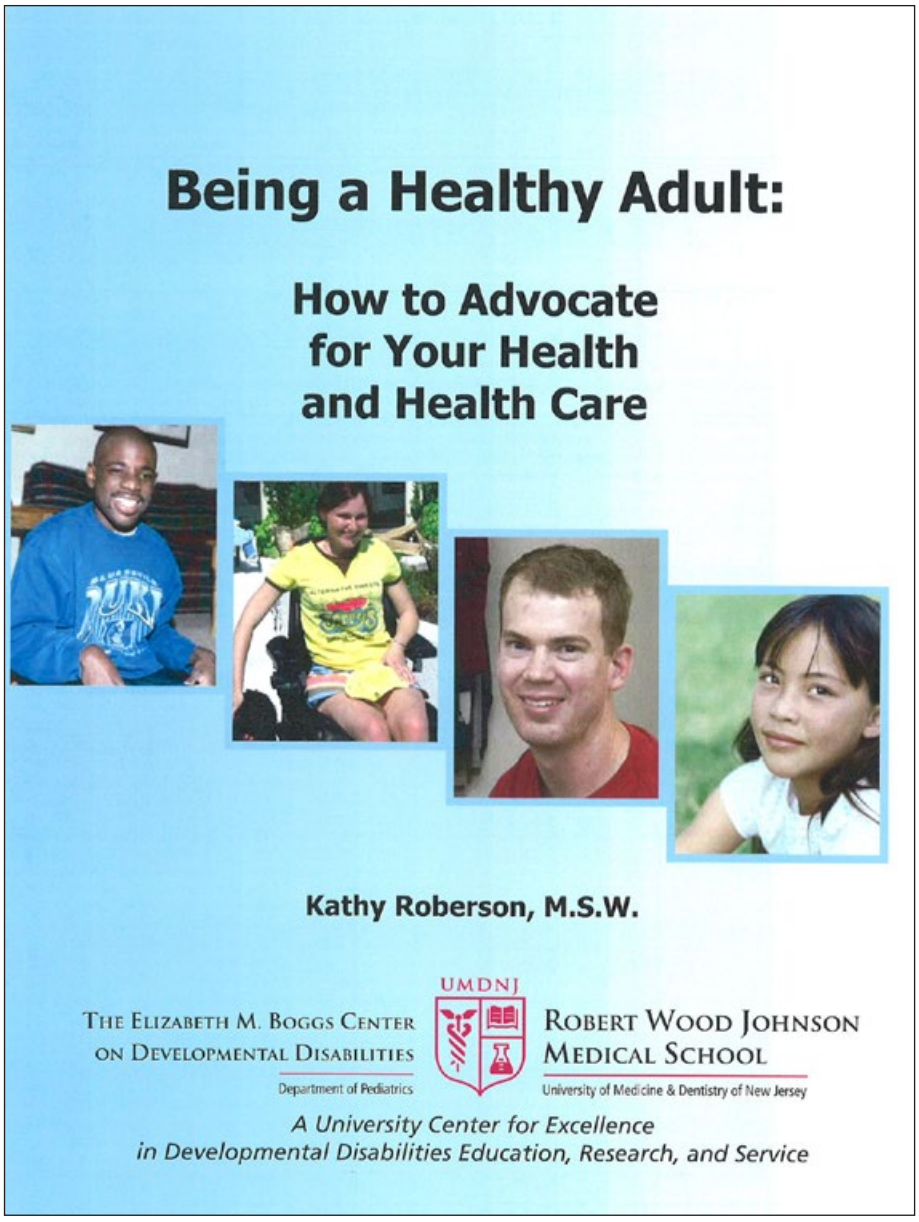
Just as we create our materials to reflect racial and ethnic diversity, it is also important to include people with disabilities in those materials—one in five California adults are living with a disability, nearly 5.7 million people. It is easy to acknowledge this significant segment of the population by including a photo of a person with a disability and inclusive disability language when revising or creating new program materials such as flyers, brochures, posters, and advertisements.

The CDPH's LHD website has a link to public domain photos you can use in developing your materials. http://www.cdph.ca.gov/programs/Pages/DisabilityandHealth.aspx

Two other photo resource libraries are available to you: http://fodh.phhp.ufl.edu/training-resources/inclusive-image-library-photo-release/ and http://phil.cdc.gov/

Here are examples of how other programs have integrated people with a disability into their materials.


DHCS
What Are My Medi-Cal Choices?
This is a guidebook for people with disabilities and seniors who have Medi-Cal.
This guidebook explains the two kinds of Medi-Cal: Regular Medi-Cal and Medi-Cal Health Plans.
This guidebook can help you choose which kind of Medi-Cal is right for you.
Questions and Answers
U


Being a Healthy Adult:
How to Advocate for Your Health and Health Care
Kathy Roberson, M.S.W.
UMDNJ
The Elizabeth M. Boggs Center on Developmental Disabilities
Department of Pediatrics
Robert Wood Johnson Medical School
University of Medicine & Dentistry of New Jersey
A University Center for Excellence in Developmental Disabilities Education, Research, and Service


New York State
WIC
Together
Growing Stronger Families

E-mails, Websites, and Electronic Documents

E-MAILS AND DOCUMENTS

- Avoid e-mail messages with excessive graphics or complex layouts and fonts. Focus on simplicity and legibility.
- Make all electronic attachments usable by assistive technology. Regardless of what other formats you use, also make files available in plain text (.txt), accessible HTML, and if possible, Rich Text Format (.rtf).

WEBSITES

- Label any image, graphic, or chart (such titles help because screen readers for the visually impaired cannot read images) and make sure the text fully describes the image, graphic, or chart.
- Ensure that all parts of the website can be accessed by keyboard alone, as many people with disabilities cannot operate a mouse.
- Do not use color to communicate key information.
- Avoid animation, moving text, auto refresh elements, and flashing elements.
- Use 12-point font or larger.
- Use sans serif typefaces such as Arial or Helvetica.
- If you must use PDF format, also include that information in a non-PDF format.
- Include links to download Acrobat Reader and Adobe System's Access page.
- Link every page to your home page.

USE OF PHOTOGRAPHS AND PICTURES

- The use of photos and pictures in accessible websites and documents is easily done; just include a label beneath each photo and/or picture explaining what is depicted making sure that the label truly describes the image. It is highly recommended to use photos or pictures of people with disabilities on your websites and in electronic documents to ensure inclusiveness. To access free, public domain photos of people with disabilities see the **Materials Development** section in this packet.

CHARTS, GRAPHS, MAPS AND TABLES

- Charts, graphs, tables, and maps are visuals used to convey complex ideas to users. But since they are images, these media are inaccessible to colorblind users and users of screen readers without an explanation of what the author wants to convey in the visuals. If the data in a chart, graph, table, or map is crucial to the content of the document then it is important to provide text to describe the visual.
- For color-blind users supplement with your charts and graphs with texture, differences in line style, text in graphs, or different shades of color to improve accessibility. Charts should be readable in black and white.
- A good resource to reference for accessible charts, graphs, maps, and tables is http://accessibility.psu.edu/charts#chartcolor.
- To see the difference between an accessible and formatted document see pages 29 – 38.

Inclusive Language for Use in Developing Sections of RFAs and RFPs

BACKGROUND SECTION

RFA # 0809170456 New York State (NYS) Department of Health RFA
Creating Healthy Places to Live, Work and Play **Excerpt**

Although the twin epidemics of obesity and diabetes affect all ages and abilities, racial and ethnic groups and socioeconomic groups, obesity and diabetes disproportionately affect some of the most vulnerable populations in New York. Low-income children and adults, African American and Hispanic residents, and those with disabilities are at higher risk of both conditions compared to medium and higher income New Yorkers, non-Hispanic white New Yorkers and New Yorkers without disabilities. In New York City, the Asian American population has the highest rate of diabetes at 16 percent. In the United States, persons with disabilities have higher rates of obesity (31.2 percent) and physical inactivity (25.3 percent) compared to those without disabilities (18.6 percent and 13.4 percent respectively). In New York, persons with disabilities are more likely to be obese (36.6 percent) than those without disabilities (22.0 percent). Youth with disabilities are 4.5 times more likely to be physically inactive compared to non-disabled youth.

PURPOSE STATEMENT

RFA # 0809170456 NYS Department of Health RFA
Creating Healthy Places to Live, Work and Play **Excerpt**

Effective community and worksite policies and supporting changes to the environment must be developed in collaboration . . . The collaborative process should include representation from diverse cultures and community members with disabilities. Develop transportation policies and environmental changes to ensure streets are safe, accessible and convenient for all users . . . users of public transit, motorists, children, the elderly, and people with disabilities. Examples include: Create community gardens by working with community planning boards, neighborhood associations, persons with disabilities, and senior and low-income housing developments. Ensure opportunities exist for employees with disabilities to adopt healthier behaviors.

BACKGROUND SECTION

RFA Number (1007301230) NYS Department of Health RFA
Comprehensive Adolescent Pregnancy Prevention Excerpt

The 2009 NYS Youth Risk Behavior Survey indicated an average of 42 percent of all high school students in 9th through the 12th grades (9th grade 26.4 percent, 10th grade 37.3 percent, 11th grade 46.2 percent and 12th grade 61.8 percent) have had sexual intercourse. An analysis of the National Longitudinal Study of Adolescent Health conducted by Cheng and Udry (2002) demonstrated that on average 43.2 percent of students with disabilities in grades 7 through 12 were sexually active. Programs that provide opportunities for youth to develop assets ultimately support youth transitioning into adulthood. Adolescents who are pregnant and/or parenting may need additional supports to continue with their normal adolescent development while additionally transitioning to early parenthood. Among adolescents with disabilities, physical and sexual maturation usually parallels that of their peers without disabilities; yet delayed emotional and cognitive development may create the need for targeted supports and approaches to enable achievement of critical developmental tasks related to sexuality. Adolescents with disabilities are increasingly becoming integrated into the larger community and typical activities of this life stage. Yet peer, provider, and societal attitudes have lagged in the recognition and support of these individuals.

PURPOSE STATEMENT

RFA Number (1007301230) **NYS Department of Health RFA**
Comprehensive Adolescent Pregnancy Prevention Excerpt

For the purpose of this RFA, reference to "high risk and disconnected youth" includes but may not be limited to youth who are: out of school; living with a disability; residing in foster care . . . The applicant will need to ensure that programming is held in fully accessible spaces and program modifications and accommodations for participants with disabilities are ascertained and provided. Applicants will need to attest to this requirement on the Statement of Assurances, Attachment 9a. Further, the adolescents who identify as having a disability, lesbian, gay, bisexual, transsexuals, and questioning (LGBTQ), immigrant, transient or sexually abused may face additional barriers that require sensitivity, professional knowledge and awareness to effectively ensure access. The societal, cultural and personal experience of adolescents with disabilities should be factored into these activities to ensure successful skill-building.

Frequently Asked Questions (FAQs)

What is meant by "disability," and what kinds of disability does that encompass?

Answer: The term disability is used here to describe a physical or mental impairment that substantially limits one or more major life activities. We use a broad definition in order to include all types of disability.

What are the benefits of having disability integrated into my program?

Answer: It is important to integrate people with disabilities into your program from a social justice perspective. You will be serving a population that is vulnerable, underserved, and often in highest need of a specific health intervention. Along with racial minorities, people with a disability are considered to be a group facing health disparities and health inequities.

Is there a place I can go to get disability related data?

Answer: The Behavioral Risk Factor Surveillance System (BRFSS), California Health Interview Survey (CHIS) and American Community Survey (ACS) collect data about people with disability. Also, CDC has a Disability and Health Data System using BRFSS data. With this system, users can customize how they view disability and health data throughout the country, making it easy to understand health disparities, identify trends, and support the development of fiscally-responsible and evidence-based programs, services and policies. http://www.cdc.gov/ncbddd/disabilityandhealth/data.html

Are there certain health conditions that place people with disabilities at a higher risk?

Answer: Chronic diseases often cause disabilities, but chronic conditions may also be the result of a disability or an unrelated condition. People with disabilities have a higher percentage of:

- Diabetes
- Asthma
- Arthritis
- Heart disease
- Obesity

See the *Disability in California Adults* Fact Sheet in this packet for more details.

Will it cost me money to include people with a disability into my program interventions?

Answer: Including people with disabilities into program interventions probably will not cost you any additional money. Any behavioral or policy interventions that work for a person without a disability will also work for most people with a disability. If you are implementing a physical intervention then there may be some additional equipment charges, depending on the intervention and disability group you are targeting.

How do I find someone with a disability to include in an Advisory Committee?

Answer: There are several places you can call to find the appropriate person with a disability to serve on an Advisory Committee/Council including the State Independent Living Center (SILC), California Foundation for Independent Living Council (CFILC). (Contact information for those organizations is on the resource list found in this packet).

How do I find disability subject area specialists to advise my program for disability related issues?

Answer: See the answer above.

Will my program be charged to have a sign language interpreter at a meeting or event and how do I make arrangements for an interpreter?

Answer: No, that service is free of charge obtained from the Office of Civil Rights (OCR) for any event/meeting or conference sponsored by CDPH. To make arrangements for a sign language interpreter, call the Office of Civil Rights at 916-445-0938. Make sure that you give them proper notice of at least 24 hours in advance of the event. For local meetings/events that are not sponsored by CDPH contact Sign Language Interpreting Services Agency at http://signinterpreting.com/ or call (916) 483-4751.

How would I approach age-specific disability issues?

Answer: You would approach age-specific disability issues in the same way that you would any other age-specific issue: research it, know what happens to people with disabilities at different ages and be sensitive and attentive to those particular issues when program planning.

If I am interested in doing a specific project involving people with disabilities where can I find people with disabilities to include in my interventions?

Answer: There are several places you can call to find the appropriate people with a disability to include in your interventions: SILC, CFILC, or a local Independent Living Center (ILC) which can be found on the CFILC website. http://www.cfilc.org/site/c.fnJFKLNnFmG/b.5192429/k.2734/List_of_California_Independent_Living_Centers.htm

Resources

NATIONAL

American Association on Health and Disability (AAHD)

The mission of AAHD is to support health promotion and wellness initiatives for children and adults with disabilities.

http://www.aahd.us/page.php

Americans with Disabilities Act (ADA) Accessibility Guidelines

This website is operated by the U.S. Department of Justice and provides ADA regulations and technical assistance materials.

http://www.ada.gov

Centers for Disease Control and Prevention (CDC)

Disability and health homepage is dedicated to providing information about how people with disabilities can live healthy lives. Healthy means the same thing for all of us—getting and staying well so we can lead full, active lives. That means having the tools and information to make healthy choices and knowing how to prevent illness.

http://www.cdc.gov/ncbddd/disabilityandhealth/healthyliving.html

National Association of County and City Health Officers (NACCHO)

This website has a free, online collection of tools produced by members of the public health community. Tools within the Toolbox are materials and resources public health professionals and other external stakeholders can use to inform and improve their work in the promotion and advancement of public health objectives for people with disabilities.

http://www.naccho.org/toolbox/veritysearch/search.cfm?keywords=Disability&x=53&y=14&p=ALL&st=ALL&jurisdiction=ALL

National Center on Physical Activity and Disability (NCPAD)

NCPAD is an information center devoted to providing resources about physical activity and disability.

http://www.ncpad.org/

http://www.cdc.gov/ncbddd/disabilityandhealth/healthyliving.html

STATE

CFILC

CFILC, based in Sacramento, is a statewide, non-profit trade organization made up of 25 ILCs. Through unified action, CFILC envisions civil rights for all people with disabilities. CFILC's mission is to support ILCs in their local communities through advocating for systems change and promoting access and integration for people with disabilities.

http://www.cfilc.org

California Department of Rehabilitation (DoR)

The Department's website provides information and links on the major laws, regulations, and areas of interest regarding disability rights and access for Californians with disabilities and other interested persons.

http://www.disabilityaccessinfo.ca.gov/

State Council on Developmental Disabilities (SCDD)

SCDD was established by state and federal law as an independent state agency to ensure that people with developmental disabilities and their families receive the services and supports they need.

http://www.scdd.ca.gov/

LHD Program

CDPH's LHD Program's mission is to promote the health and quality of life of people with disabilities (PWD) and to prevent or lessen the effects of secondary conditions through collaborative leadership to affect environmental, policy, and systems changes.

http://www.cdph.ca.gov/programs/Pages/DisabilityandHealth.aspx

Pacific ADA Center

The purpose of the Pacific ADA Center is to build a partnership between the disability and business communities and to promote full and unrestricted participation in society for persons with disabilities through education and technical assistance.

http://www.adapacific.org/

SILC

SILC is an 18-member council, appointed by the Governor, to represent persons with disabilities throughout the state.

http://www.calsilc.org/

CDPH's OCR

The mission of the Department's OCR is to administer CDPH's equal employment opportunity and civil rights programs to ensure that the Department is in compliance with state and federal civil rights laws and maintains fair and equitable policies and procedures that will result in a work environment free of discrimination.

They can be reached by calling (916) 445-0938 or
http://cdphintranet/employees/Pages/OCR.aspx.

Example of Non-accessible Document

California Department of Public Health~Safe & Active Communities (SAC) Branch~Living Healthy with a Disability Program Summer, 2009

"Every life has value and every person has promise. The reality is that for too long we provided lesser care to people with disabilities."[1]
~Richard H. Carmona, MD, MPH, FACS, Former US Surgeon General

DISABILITY IN CALIFORNIA ADULTS

The mission of the Living Healthy with a Disability Program at the California Department of Public Health is to promote the health and quality of life of people with disabilities and to prevent or lessen the effects of secondary conditions through collaboration, environmental, policy and system change, leadership, science and service.

Data from the 2007 Behavioral Risk Factor Survey (BRFS) is used here to characterize the population of California adults with disability and explore issues that challenge their ability to live healthy lives with a disability.

A PROFILE OF DISABILITY IN CALIFORNIA

The term disability is used here to describe a long-lasting physical, mental, or emotional condition.[2]

- Nearly 5.7 million adults in California are people with a disability (PWD) (23%).

GENDER, AGE & RACE/ETHNICITY

- Twenty percent of men and 26% of women report having a disability.
- Disability in adults increases with age: 15% of those aged 18-44 years, 28% of those aged 45-64 years and 43% of those aged 65 years and older have a disability.
- Disability is highest among Black, Non-Hispanic (26%), White, Non-Hispanic (25%) and American Indian/Alaska native populations (24%). The rates are lower among Hispanics (22%), Native Hawaiian or other Pacific Islander (17%) and Asian (16%) populations.

EDUCATION & EMPLOYMENT

- Among those with a disability, 20% have not completed high school, compared to 14% of those with no disability.
- Among working-age adults with disability (18-64 years), 52% are employed for wages or self-employed, compared to 72% of those without disability.

SOCIOECONOMIC STATUS

- Among adults with a disability, 24% live below the poverty line compared to 16% of those without disability.

A DESCRIPTION OF DISABILITY TYPE

	Estimated CA pop. millions	%
Physical: (A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying)	3.2	13%
Mental: (Difficulty learning, remembering or concentrating due to a physical, mental, or emotional condition lasting six months or more)	2.7	11%
Sensory: (Blind, deaf or a severe vision or hearing problem)	1.3	5%
Work: (Difficulty working at a job or business due to a physical, mental, or emotional condition lasting six months or more)	1.5	7%
Going-outside: (Difficulty going outside the home alone to shop or visit a doctor's office due to a physical, mental, or emotional condition lasting six months or more)	1.0	4%
Self-care: (Difficulty dressing, bathing, or getting around inside the home due to a physical, mental, or emotional condition lasting six months or more)	0.7	3%
A person may have more than one of these disability types, 23% of the population (nearly 5.7 million adults) has at least one.		

PUBLIC HEALTH MESSAGE

Disability eventually affects everybody, directly or indirectly. Nearly one in four California adults report a disability, and it is more likely in vulnerable groups such as the elderly and impoverished. PWD face more challenges to staying healthy than others: they are more likely to smoke, and to be overweight and sedentary. They often lack health insurance coverage and delay or forego regular medical care.

The numbers of PWD are growing as the population ages and PWD are surviving longer. It is important to provide appropriate services and accessible resources to this underserved and vulnerable population.

Here are some simple ways to include the disability population within public health programs:

- Ensure the language used in request for applications (RFAs) includes PWD along with other vulnerable populations
- include PWD in intervention strategies
- provide all materials in alternate formats (such as Braille, large type and audio)
- host accessible websites (such as those with clear and simple language, audio captioning, and line-by-line reading that can be used with screen readers)
- ensure PWD are included in strategic planning sessions, and
- include PWD on Advisory Committees and Councils

Disability in California Adults

Disability & Health-Related Quality of Life

- Adults with a disability are three times more likely to report fair or poor health status than adults without disability (34% compared to 10%).
- Among those with a disability, 58% reported that poor health restricted their usual activities (including self care, work or recreation) for 14 or more days a month, compared to 35% among people without disability.

Disability & Health Behaviors

Physical Activity & Obesity

- Adults with a disability are more likely to be inactive. Among adults with disability, 30% do not engage in any physical activity (other than their job, if applicable), compared to 20% of adults without disability.
- Adults with a disability are more likely to be obese than those without a disability (30% compared to 20%).

Smoking

- Adults with a disability are more likely to be smokers than those without a disability (19% compared to 14%).

Disability & Chronic Health Conditions

- Among adults with a disability, 45% report having a chronic health condition, compared to 17% of those without disability. The following chronic conditions may be the cause of their disability, a result of their disability, or an unrelated health condition.

Diabetes

- Among adults with a disability, 13% report having diabetes, compared to 5% among those without disability.

Asthma

- Among adults with a disability, 17% report having asthma compared to 12% of adults without disability.

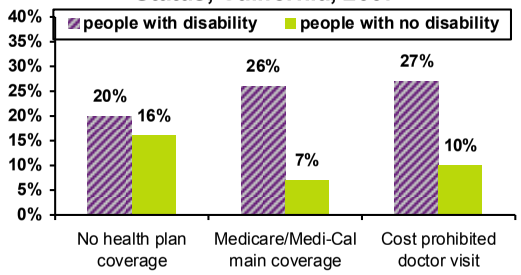
Arthritis

- Among adults with a disability, 41% have been told they have some form of arthritis, compared to 13% of adults without disability.

Heart Disease

- Adults with a disability are more likely to have been told by a doctor that they have high blood pressure (40% of those with disability and 19% of those without) and high cholesterol (45% of those with disability and 30% of those without).

Health Care Access by Disability Status, California, 2007



Source: State of California, Department of Public Health, Behavioral Risk Factor Survey (BRFS), 2007

Disability & Health Care Access

Insurance Coverage

- Adults with a disability are less likely than those without a disability to be covered by a health plan. Among those 18-64 years of age, 20% of persons with disability have no coverage compared to 16% of those without disability.
- Among those that have health coverage, working-age adults with a disability are much more likely to use Medicare/Medi-Cal as their main coverage (26%) compared to working-age adults without disability (7%).

Delay of Care

- When asked if they had needed to see a doctor in the past year but didn't because of cost, 21% of those with a disability said yes compared to only 10% of those without disability.

Data Source

The data presented here is from the 2007 California Behavioral Risk Factor Survey (BRFS), an annual survey of health-related behaviors in the adult population aged 18 years and older.[3] Disability is defined using six questions[2] adapted from The American Community Survey produced by the US Census Bureau.[4]

References & Notes

[1] The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities, July 26, 2005

[2] The six specific questions used to identify disability were: 1) Are you blind or deaf, or do you have a severe vision or hearing problem? 2) Do you have a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying? 3) Because of a physical, mental, or emotional condition lasting 6 months or more, do you have any of the following: Any difficulty learning, remembering, or concentrating? 4) Any difficulty dressing, bathing, or getting around inside the home? 5) Any difficulty going outside the home alone to shop or visit a doctor's office? 6) Any difficulty working at a job or business? Disability is defined as a positive response to at least one of these questions. A positive response to an individual question is referred to as: sensory disability, physical disability, mental disability, self-care disability, going-outside disability, and work disability, respectively.

[3] State of California, Department of Public Health, California Behavioral Risk Factor Survey (BRFS), 2007.

[4] United States Census Bureau, Housing and Household Economic Statistics Division, American Community Survey. More information is available at: http://www.census.gov/hhes/www/disability/acs.html.

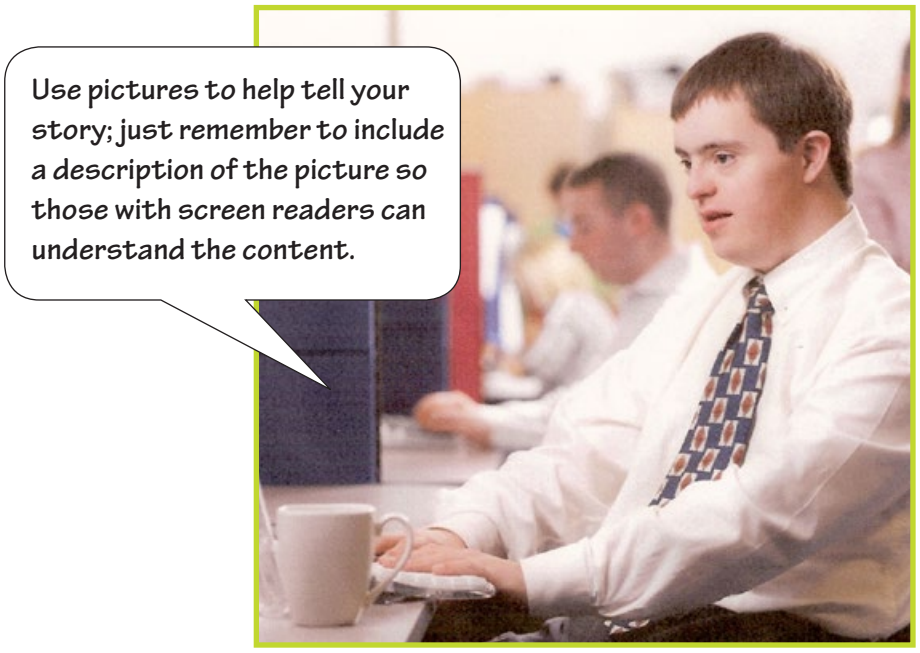
Suggested Citation: Disability in California, Summer 2009, California Department of Public Health, SAC Branch, Living Healthy with a Disability Program

This fact sheet is available in accessible format at www.cdph.ca.gov/programs/Pages/DisabilityandHealth.aspx or by request at (916)552-9840.

Previous Example Revised Into Accessible Format

(pages 31–38)

Disability in California ADULTS



Young man in job training program

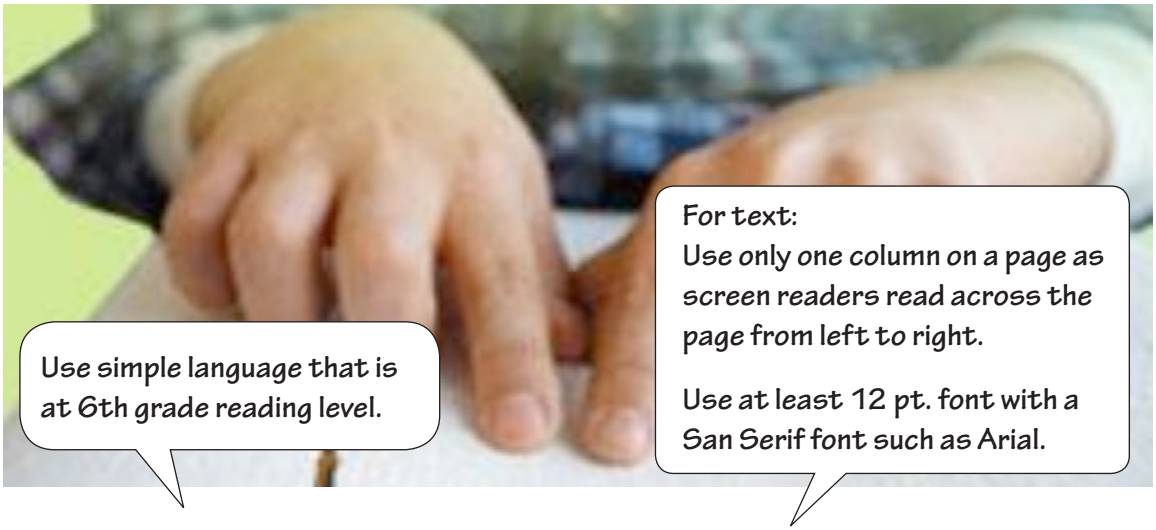
Every life has value and every person has promise. The reality is that for too long we provided lesser care to people with disabilities.[1]

~ Richard H. Carmona, MD, MPH, FACS, Former US Surgeon General

Safe and Active communities

California Department of PublicHealth

California Department of Public Health, Safe & Active Communities (SAC) Branch, Living Healthy with a Disability Program, Summer, 2009



The mission of LHD Program at the CDPH is to promote the health and quality of life of people with disabilities and to prevent or lessen the effects of secondary conditions through collaboration, environmental, policy and system change, leadership, science, and service.

Data from the 2007 Behavioral Risk Factor Survey (BRFS) is used here to characterize the population of CA adults with disability and explore issues that challenge their ability to live healthy lives with a disability.

A Profile of Disability in California

The term disability is used here to describe a long-lasting physical, mental, or emotional condition.[2]

- Nearly 5.7 million adults in California are people with a disability (23 percent).

Gender, Age & Race/Ethnicity

- 20 percent of men and 26 percent of women report having a disability.
- Disability in adults increases with age: 15 percent of those aged 18-44 years, 28 percent of those aged 45-64 years and 43 percent of those aged 65 years and older have a disability.
- Disability is highest among Black, Non-Hispanic (26 percent), White, Non-Hispanic (25 percent) and American Indian/Alaska native populations (24 percent). The rates are lower among Hispanics (22 percent), Native Hawaiian or other Pacific Islander (17 percent) and Asian (16 percent) populations.

A Description of Disability Type

	Estimated CA pop. millions	%
PHYSICAL: A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying.	3.2	13%
MENTAL: Difficulty learning, remembering or concentrating due to a physical, mental, or emotional condition lasting six months or more.	2.7	11%
SENSORY: Blind, deaf, or a severe vision or hearing problem.	1.3	5%
WORK: Difficulty working at a job or business due to a physical, mental, or emotional condition lasting six months or more.	1.5	7%
Going-outside: Difficulty going outside the home alone to shop or visit a doctor's office due to a physical, mental, or emotional condition lasting six months or more.	1.0	4%
SELF-CARE: Difficulty dressing, bathing, or getting around inside the home due to a physical, mental, or emotional condition lasting six months or more.	0.7	3%
A person may have more than one of these disability types, 23% of the population (nearly 5.7 million adults) has at least one.		

Education & Employment

Among those with a disability, 20 percent have not completed high school, compared to 14 percent of those with no disability.

- Among working-age adults with disability (18-64 years), 52 percent are employed for wages or self-employed, compared to 72 percent of those without disability.

Socioeconomic Status

- Among adults with a disability, 24 percent live below the poverty line compared to 16 percent of those without disability.

Disability & Health-Related Quality of Life

- Adults with a disability are three times more likely to report fair or poor health status than adults without disability (34 percent compared to 10 percent).
- Among those with a disability, 58 percent reported that poor health restricted their usual activities (including self care, work or recreation) for 14 or more days a month, compared to 35 percent among people without disability.

Disability & Health Behaviors

Physical Activity & Obesity

- Adults with a disability are more likely to be inactive. Among adults with disability, 30 percent do not engage in any physical activity (other than their job, if applicable), compared to 20 percent of adults without disability.
- Adults with a disability are more likely to be obese than those without a disability (30 percent compared to 20 percent).

Smoking

- Adults with a disability are more likely to be smokers than those without a disability (19 percent compared to 14 percent).

Disability & Chronic Health Conditions

- Among adults with a disability, 45 percent report having a chronic health condition, compared to 17 percent of those without disability. The following chronic conditions may be the cause of their disability, a result of their disability, or an unrelated health condition.

Diabetes

- Among adults with a disability, 13 percent report having diabetes, compared to 5 percent among those without disability.

Asthma

- Among adults with a disability, 17 percent report having asthma compared to 12 percent of adults without disability.

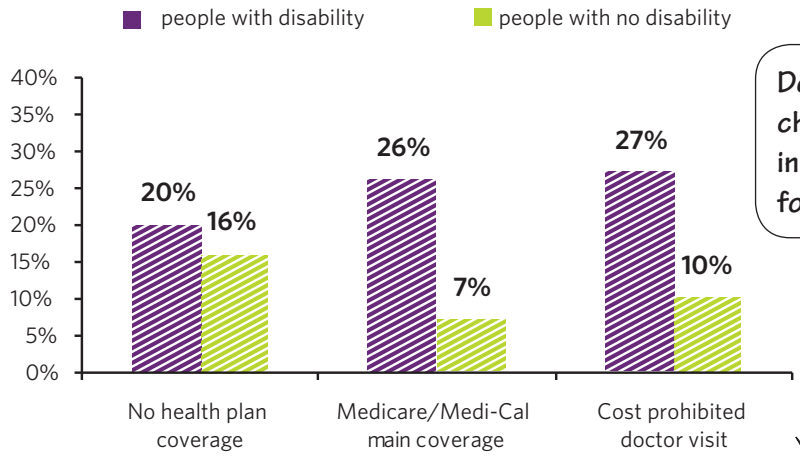
Arthritis

- Among adults with a disability, 41 percent have been told they have some form of arthritis, compared to 13 percent of adults without disability.

Heart Disease

- Adults with a disability are more likely to have been told by a doctor that they have high blood pressure (40 percent of those with disability and 19 percent of those without) and high cholesterol (45 percent of those with disability and 30 percent of those without).

Health Care Access by Disability Status, California, 2007



Source: State of California, Department of Public Health, Behavioral Risk Factor Survey (BRFS), 2007

Describe your chart or graph in narrative form.

For Charts and Graphs: Use hash marks or equivalent to distinguish between different values on charts and graphs.

Disability & Health Care Access

Insurance Coverage

- Adults with a disability are less likely than those without a disability to be covered by a health plan. Among those 18-64 years of age, 20 percent of persons with disability have no coverage compared to 16 percent of those without disability.
- Among those that have health coverage, working-age adults with a disability are much more likely to use Medicare/Medi-Cal as their main coverage (26 percent) compared to working-age adults without disability (7 percent).

Delay of Care

- When asked if they had needed to see a doctor in the past year but didn't because of cost, 21 percent of those with a disability said yes compared to only 10 percent of those without disability.

Data Source

The data presented here is from the 2007 BRFS, an annual survey of health-related behaviors in the adult population aged 18 years and older.[3] Disability is defined using six questions[2] adapted from The American Community Survey produced by the US Census Bureau.[4]

Public Health Message

Disability eventually affects everybody, directly or indirectly. Nearly one in four California adults report a disability, and it is more likely in vulnerable groups such as the elderly and impoverished. PWD face more challenges to staying healthy than others: they are more likely to smoke, and to be overweight and sedentary. They often lack health insurance coverage and delay or forego regular medical care.

The numbers of PWD are growing as the population ages and PWD are surviving longer. It is important to provide appropriate services and accessible resources to this underserved and vulnerable population.

Here are some simple ways to include the disability population within public health programs:

- Ensure the language used in RFAs includes PWD along with other vulnerable populations;
- Include PWD in intervention strategies;
- Provide all materials in alternate formats (such as Braille, large type, and audio);
- Host accessible websites (such as those with clear and simple language, audio captioning, and line-by-line reading that can be used with screen readers);
- Ensure PWD are included in strategic planning sessions; and,
- Include PWD on Advisory Committees and Councils.

References & Notes

1. The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities, July 26, 2005.

2. The six specific questions used to identify disability were: 1) Are you blind or deaf, or do you have a severe vision or hearing problem? 2) Do you have a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying? 3) Because of a physical, mental, or emotional condition lasting 6 months or more, do you have any of the following: Any difficulty learning, remembering, or concentrating? 4) Any difficulty dressing, bathing, or getting around inside the home? 5) Any difficulty going outside the home alone to shop or visit a doctor's office? 6) Any difficulty working at a job or business? Disability is defined as a positive response to at least one of these questions. A positive response to an individual question is referred to as: sensory disability, physical disability, mental disability, self-care disability, going-outside disability, and work disability, respectively.

3. State of CDPH, California BRFS, 2007.

4. United States Census Bureau, Housing and Household Economic Statistics Division, American Community Survey. More information is available at: http://www.census.gov/hhes/www/disability/acs.html.

Suggested Citation: Disability in California, Summer 2009, CDPH, SAC Branch, LHD Program

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Overweight, Obesity and Lack of Physical Activity Among California Women with a Disability, 2007

Julie Cross Riedel, Ph.D.
CDPH, EPIC Branch, LHD Program

Obesity and lack of physical activity are widely recognized as risk factors for poor health. They have been associated with an increase in a variety of chronic diseases including cardiovascular disease, hypertension, type-2 diabetes, and depression.[1, 2] Because of their importance to health, *Healthy People 2010* objectives were defined targeting both obesity and physical activity.[3] Women with disabilities may be more likely than other women to be overweight, and less likely to engage in regular physical activity, due to the activity limitations and changes in mobility often associated with disability. Thus, women with a disability may face health threats associated with excess weight in addition to their disabling condition. This report uses the California Women's Health Survey (CWHS) to assess the prevalence of being overweight or obese and engaging in physical activity among women with and without disability.

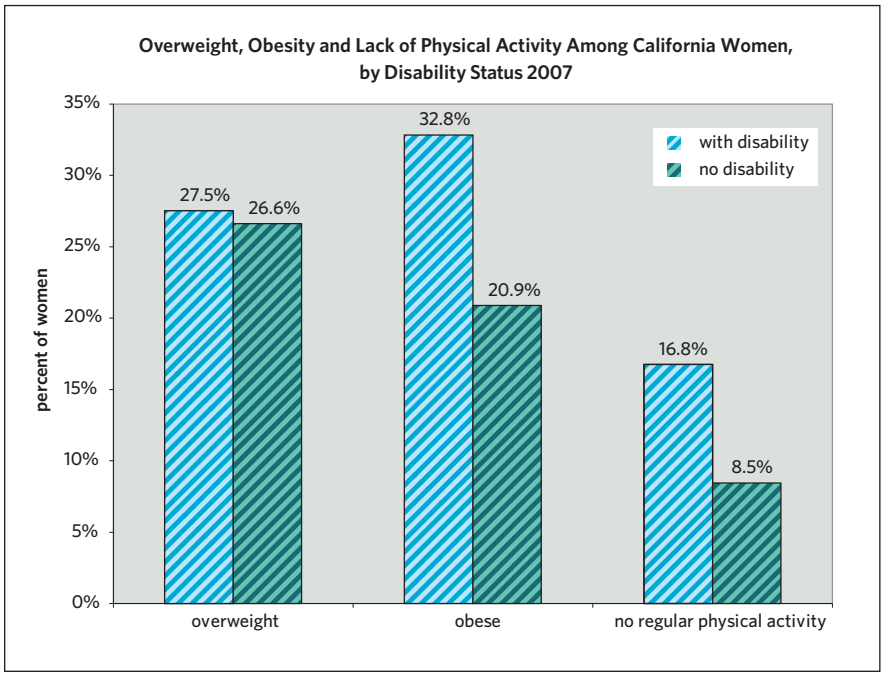
Women with a disability were identified on the 2007 CWHS by a "yes" response to either of these two questions: 1. **"Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?"** and 2. **"Are you limited in any way in any activities because of a physical, mental, or emotional problem?"** Body Mass Index (BMI), a standard measure used to categorize weight, was calculated using a woman's self-reported height and weight. Women with a BMI of 25 to 29.99 were classified as being overweight and women with a BMI of 30 or greater were classified as obese.[4] To assess physical activity, women were asked how many days in a usual week they did *"moderate or vigorous activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate."* Women who responded "none" to this question were classified as engaging in no regular physical activity. Responses were weighted in these analyses by age and race/ethnicity to reflect the 2000 California adult female population.

In 2007, 22.3 percent of CWHS respondents reported having a disability. Similar percentages of women with and without a disability were overweight (27.5 percent and 26.6 percent). However, there was a considerable difference in prevalence of obesity between women with a disability (32.8 percent) and women with no disability (20.9 percent; $p<0.0001$). Similarly, twice as many women with a disability reported not engaging in regular physical activity (16.8 percent) compared to those without disability (8.5 percent; $p<0.0001$).

The observed association between obesity, physical activity, and disability is made up of complex interrelationships. While a causal relationship between disability and obesity cannot be determined with this data, the results indicate a strong association that needs to be addressed. Disability can lead to obesity by affecting a woman's mobility and energy and consequently affecting the amount of physical activity she can do. Conversely, obesity can cause disability as it may lead to activity limitations.

PUBLIC HEALTH MESSAGE

One in three women with a disability is obese and one in six does not participate in any regular physical activity. Clearly, women with a disability are a vulnerable population at risk for health problems due to excess weight. It is vital that health promotion activities, such as weight control and exercise options be available, accessible, and affordable to women with disabilities.[5]



Source: California Women's Health Survey, 2007

[1.] The Centers for Disease Control and Prevention: Division of Nutrition, Physical Activity and Obesity, *Overweight and Obesity, 2007.*
Available at: http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm

[2.] The Centers for Disease Control and Prevention: Division of Nutrition, Physical Activity and Obesity, *Physical Activity for a Health Weight.* Available at: http://www.cdc.gov/nccdphp/dnpa/healthyweight/physical_activity/index.htm

[3.] U.S. Department of Health and Human Services. *Healthy People 2010. Understanding and Improving Health.* 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

[4.] The Centers for Disease Control and Prevention: Division of Nutrition, Physical Activity and Obesity, *Assessing your Weight.*
Available at: http://www.cdc.gov/nccdphp/dnpa/healthyweight/assessing/index.htm

[5.] Rimmer, J.H, Riley. B., Wang. E., Rauworth, A., & Jurkowski, J. Physical activity participation among persons with disabilities: Barriers and facilitators. Am J Prev Med. 2004; 26(5): 419-25.

Submitted by: Julie Cross Riedel, Ph.D., CDPH, EPIC Branch, LHD Program, (916)552-9851, JulieCrossRiedel@cdph.ca.gov.

Mental Health Needs Among California Women with a Disability, 2007

Julie Cross Riedel, Ph.D.
CDPH, EPIC Branch, LHD Program

Mental disorders such as depression are among the leading causes of poor health worldwide.[1] According to the 2000 American Community Survey, 22 percent of women in the United States had a disability and nearly one quarter of these had a mental disability. Disability type is not mutually exclusive and the majority of those with a mental disability cited another type of disability as well (for example, physical or sensory).[2] For some, mental health may be the primary disabling condition, while for others mental health issues occur secondary to a physical disability. This report uses the California Women's Health Survey (CWHS) to assess the overall increase in mental health needs among women with a disability.

Women with a disability were identified on the 2007 CWHS by a "yes" response to either of two questions: 1. **"Do you now have any health problem that requires you to use special equipment, such as a cane, a wheel chair, a special bed, or a special telephone?"** and 2. **"Are you limited in any way in any activities because of a physical, mental, or emotional problem?"** The level of depressive symptoms was measured using the Patient Health Questionnaire (PHQ), a screening tool designed to identify the presence of depression.[3] Responses were scored to create a total PHQ score, with a value of ten or greater identifying clinically significant depressive symptoms. Feeling overwhelmed was measured by the question: "**In the past 30 days, how often have you felt problems were piling up so high that you could not overcome them?**" A desire for mental health help was measured by the question: "**In the past 12 months did you ever want help with personal or family problems from a mental health professional or religious or spiritual leader?**" Responses were weighted in these analyses by age and race/ethnicity to reflect the 2000 California adult female population.

In 2007, 22.3 percent of CWHS respondents reported having a disability. Women with a disability had a higher prevalence of mental health issues examined here.[4] Compared to women without a disability, women with a disability:

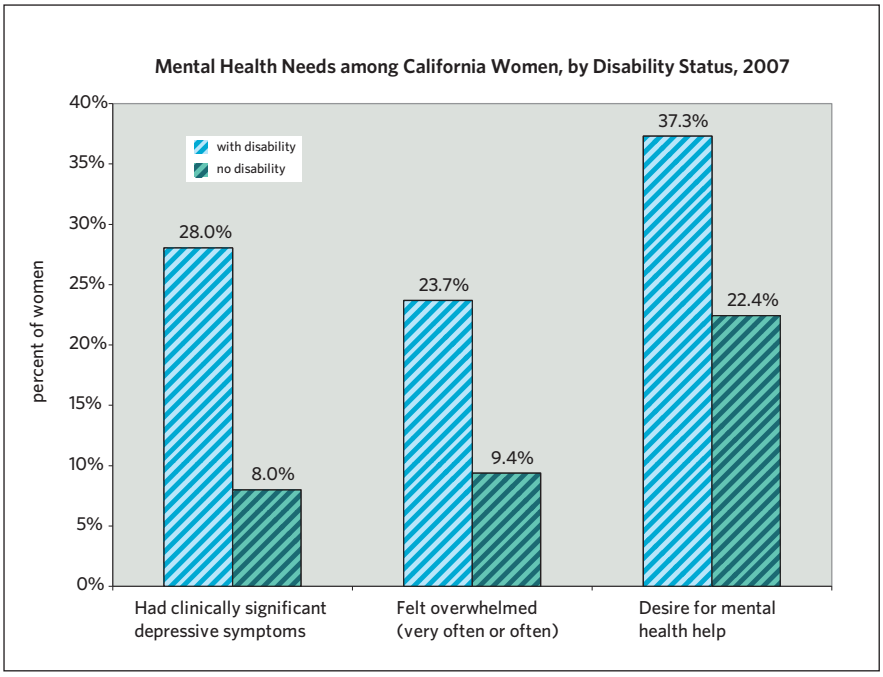
- were more than three times as likely to have depressive symptoms (28.0 percent versus 8.0 percent),
- had a higher PHQ score, indicating a greater severity level of depressive symptoms (mean score of 6.9 versus 3.5),

- were more than twice as likely to feel overwhelmed often or very often (23.7 percent versus 9.4 percent),
- were more likely to need mental health help for a personal problem (37.3 percent versus 22.4 percent). Interestingly, there was no difference in the portion of women that received help (68.3 percent of disabled women received the help they needed, compared to 68.0 percent of women without a disability).

Disability and mental health problems are often found concurrently, and it is not possible here to determine whether the mental health issues described are the primary cause of disability or are a consequence of another disabling condition. It is clear, however, that there is an increase in mental health needs among women with a disability.

PUBLIC HEALTH MESSAGE

Women with a disability are more likely than women without a disability to face a variety of mental health problems including increased prevalence of depressive symptoms, likelihood of feeling overwhelmed, and need for professional mental health help for personal problems. It is important that treatment and prevention activities are available, accessible, and affordable for people with disabilities, and that policies dealing with mental health include this vulnerable population.



Source: California Women's Health Survey, 2007

[1.] World Health Organization. *The Global Burden of Disease: 2004 Update*. Switzerland, 2008.

[2.] Waldrop, J. & Stern, SM. *Disability Status: 2000.* Census 2000 Brief. US Census Bureau, March 2003.

[3.] Kroenke, K, & Spitzer, RL. The PHQ-9: A new depression diagnositic and severity measure. Psychiatric Annals. 2002; 32(9):1-7.

[4.] All comparisons reported here are statistically significant at $p<0.0001$.

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Food Security and Health Status among California Women with a Disability, 2008

Julie Cross Riedel, Ph.D.
CDPH, EPIC Branch, LHD Program

Food security, or ready access to enough food at all times, has been found to be a powerful measure of poverty and unmet need.[1] Limited access to food is an obvious threat to health, and the food that people with low food security do eat is often high in fat and low in good nutrition. It has been shown that people with a disability are more likely to live in poverty and thus they are more likely to face issues with food security.[2] Additionally, people with a disability often have poor health, both because poor health may be part of the disability and because disability is often associated with inactivity and obesity.[2,3] A key goal of the Living Healthy with a Disability Program at the California Department of Public Health is to improve the health and quality of life of people with a disability. This report uses the California Women's Health Survey (CWHS) to examine the vulnerable population of women with a disability and explore whether those with poorer health are also those with the greatest level of food insecurity.

Women with a disability (WWD) were identified in the CWHS as those either limited in activities due to a physical, mental or emotional problem, or those requiring the use of special equipment (such as a cane, wheelchair, or special telephone) for a health problem. A validated set of six questions about food supply and monetary constraints during the previous year was used to categorize women as "food secure" or "food insecure".[4,5] Four questions were used as indicators of health status:[6]

1. General health: the respondents' ranking of their general health (excellent, very good, good, fair, or poor);
2. Physical health: the number of days in the previous month the respondent said their physical health was not good;
3. Mental health: the number of days in the previous month the respondent said their mental health was not good; and

Activity restrictions: the number of days in the previous month the respondent said their usual activities (such as self-care, work, or recreation) were restricted by poor health.

For each of these questions, health status was classified as either good or poor, with poor representing the respondent's ranking of their general health as fair or poor and reporting 14 or more days for the other three questions. Responses were weighted in these analyses by age and race/ethnicity to reflect the 2000 California adult female population.

In 2008, 20.4 percent of respondents to the CWHS had a disability. Thirty-five percent of these were food insecure (compared to 22.8 percent of women without disability).[7]

Among women with a disability, in each of the measures of health status, those with poor health were also more likely to be food insecure. [7]

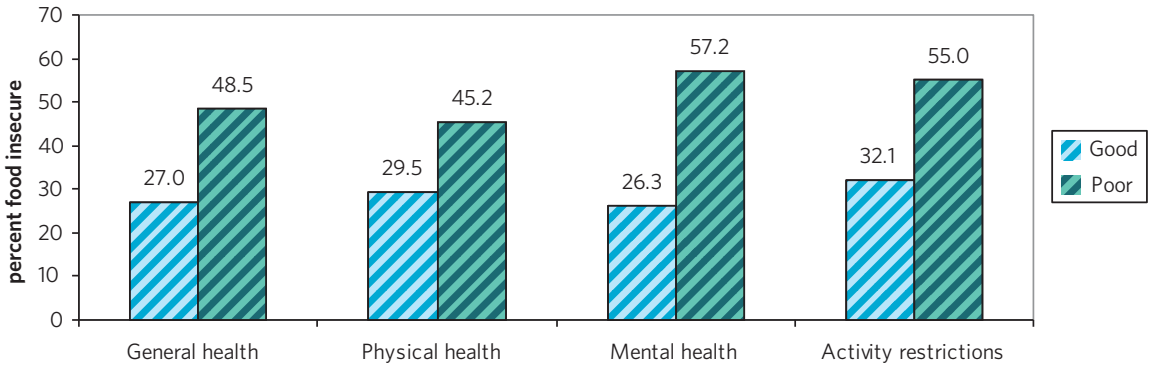
- WWD who ranked poorly in general health status were nearly twice as likely to be food insecure than those ranking good on this measure (48.5 percent versus 27 percent).
- WWD who ranked poorly in physical health were 1.5 times more likely to be food insecure than those ranking good on this measure (45.2 percent versus 30 percent).
- WWD who ranked poorly in mental health were more than twice as likely to be food insecure than those ranking good on this measure (57.2 percent versus 26.3 percent).
- WWD who ranked poorly in activity restrictions were 1.7 times more likely to be food insecure than those ranking good on this measure (55 percent versus 32.1 percent).

Among women with a disability, the sickest women had the lowest level of food security. This represents an extremely fragile population, vulnerable to long term chronic health problems often exacerbated by particular disabilities. The causal nature of the relationship between food security and health status in those with a disability is unclear, and further research needs to describe precisely the role food security plays in the lives of women with a disability.

PUBLIC HEALTH MESSAGE

California women with a disability are more likely than those without disability to have issues of food insecurity. This is particularly true among those with a disability and with poor health, with one in two having limited access to food. When implementing public health policies and interventions, it is important to address food security by providing appropriate support, services and accessible resources to this underserved and vulnerable population. Ways to do this include promoting the availability of accessible transportation to buy affordable groceries, making food delivery services available, and ensuring that public safety nets (such as food banks and food stamps) are useable by all people, including those with a disability.

Food Insecurity and Health Status among California Women with a Disability, 2008



Source: California Women's Health Survey (CWHS), 2008

1. Food Security in the United States [Internet]. United States Department of Agriculture, Economic Research Service; 2009 Nov. Available from: http://www.ers.usda.gov/briefing/foodsecurity/.

2. Disability in California, Summer 2009, California Department of Public Health, SAC Branch, Living Healthy with a Disability Program.

3. Disability and Health State Chartbook - 2006: Profiles of Health for Adults with Disabilities [Internet]. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention; 2009 March. Available from: http://www.cdc.gov/ncbddd/dh/chartbook/default.htm

4. Food security in the United States: Measuring Household Food Security [Internet]. United States Department of Agriculture, Economic Research Service; 2008 Nov 17. Available from: http://www.ers.usda.gov/Briefing/FoodSecurity/measurement.htm.

5. U.S. Household Food Security Module: Six-Item Short Form [Internet]. United States Department of Agriculture; 2008 July. Available from: http://www.ers.usda.gov/Briefing/foodsecurity/surveytools/short2008.pdf.

6. Health-Related Quality of Life [Internet]. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention; 2009 Jan. Available from: http://www.cdc.gov/hrqol/.

7. All $p<0.0001$.

Submitted by: Julie Cross Riedel, PhD, Nancy Guenther, MST, *CDPH, SAC Branch, LHD Program*, (916) 552-9851, julie.crossriedel@cdph.ca.gov


Safe and Active
communities


California Department of
PublicHealth